PLEASE PRINT
Attach additional pages if more space is needed

HealthChoice/DHMH
Outpatient Concurrent Review
Authorization of Care

Date contact made to MCO:_____ Time:_____am / pm	MCO Name _____ Contact Name_____	Date confirmation received from MCO:_____ Time:_____ am / pm

Please complete all sections. For confidentiality purposes, please do not write the client's name in the body of the treatment plan.This information has been disclosed to you from records protected by Federal confidentiality rules (CFR 42 – part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42- Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient..

1.Client's First Name Only	2. Client's Date of Birth _____/_____/_____ Mo Day Yr	3. Client's Sex M___ F___	4a. Client's MCO Number 4b. Client's MA Number
5. Group Number*	6. Client's Address & Phone Number		

7. Clinician's Name (Printed) _____ _____ Clinician's Signature Date	8. Clinic/Program Name, Address & Phone number

9. MA Provider Number	10. Referral Source	11. Primary Care Physician	12. Date of Last Exam

13a. Date of Last Communication to Primary Care Physician_____ 13b. Release Signed? Yes_____ No_____	14. If Primary Care Physician not seen, indicate why:
15a. Client Pregnant? Yes____ No____ 15b. If Yes, Due Date _____	16. OB/GYN:_____ a. Pre Natal Appt Scheduled:_____ b. Pre Natal Appt Completed:_____ c. OB/GYN Knows of Pregnancy? Yes____ No____

17. Date Present Treatment Began (mo, day, yr)

18. Diagnosis (Please complete all axes.) Use DSMIV Codes

AXIS I

AXIS II

AXIS III

AXIS IV

AXIS V (GAF)

19. Response to Treatment (List specific gains made since initial treatment plan and all remaining symptoms with frequency and severity.)

20. Brief Mental Status

21. List All Medications (including Methadone/LAAM)

Type	Dosage	Start Date	Response

*

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22. If medications are being administered by someone other than yourself, please identify.

23. Reasons for Continuing Treatment: (Including current ASAM Dimensions met)

24. Statement of Problem/s

Goals related to Presenting Problems (use finite / measurable / observable terms)**
** 12 STEP/Community Support/Spirituality

Short term:
1)

2)

3)

Long term:

1)

2)

3)

_____ _____
Client's Signature Date

25. Urine Drug Screens/Breathalyzer Results Last 6 Tests

Positive Dates	Drug/Alcohol Screens	**Negative** Dates

26. Type of Treatment Requested

	Frequency/Week	Duration of **EACH** Session
IOP_____	_____	_____
Methadone Maintenance/LAAM_____	_____	_____
Individual Behavior Therapy _____	_____	_____
Group _____	_____	_____
Other_____	_____	_____

27. Anticipated Discharge Date:

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28. After Care Plan

29. Comments (e.g. employment, family, housing, health status, socialization, support system)

30. **Methadone Maintenance/LAAM Only**

A. Current Dosage_____
B. Discussed Therapeutic Detox with Client?
Yes_____ Explain:

No_____ Explain:

31.A. Is client currently using alcohol and/or illicit drugs? Yes____ No____

B.List interventions to address usage (e.g. Administrative detox, change in level of care):